MINUTES OF THE
BOARD OF COMMUNITY HEALTH MEETING
May 8, 2008

Members Present

Richard Holmes, Chairman
Ross Mason, Vice Chairman
Dr. Inman C. "Buddy" English
Kim Gay
Frank Jones
Dr. Ann McKee Parker
Raymond Riddle
Richard Robinson
Archer Rose

The Board of Community Health held its regularly scheduled monthly meeting at the Department of Community Health, Fifth Floor Board Room, 2 Peachtree Street, N.W., Atlanta, Georgia. Commissioner Rhonda Medows was present. (An agenda and a list of Attendees are attached hereto and made official parts of these Minutes as Attachments #1 and #2). Chairman Holmes called the meeting to order at 10:48 a.m.

Approval of Minutes

The Minutes of the March 13, 2008 Meeting were UNANIMOUSLY APPROVED AND ADOPTED.

Chairman's Comments

Chairman Holmes announced the resignation of board member Frank Jones and thanked him for his service to the Board and the Audit Committee.

Committee Reports

Ms. Gay, Chair of the Care Management Committee, reported that the Committee was given an update on the Managed Care Division's leadership and organizational changes, CMO contracts, CMO business continuity plan and House Bill 1234.

Commissioner's Comments

Dr. Rhonda Medows, Commissioner of DCH, reported that the state's Transparency Web Site contract had been awarded to the IBM Corporation. The Department was awarded a Health Information Security and Privacy Collaboration (HISPC) grant and will participate in the consumer education and engagement collaborative. Lastly, Dr. Medows informed the board that parts of the DHR Office of Regulatory Services will be transitioning to the DCH as part of Senate Bill 433.

Department Updates

Chairman Holmes asked Russell Crutchfield, Legislative Liaison, to give the 2008 Legislative Session Wrap-up. Mr. Crutchfield reported that both bills in the DCH legislative packet passed. House Bill 1222 relates to the Georgia Volunteer Health Care Program and amends the statute to allow DCH discretion over contracting with health care professionals sanctioned with serious board actions and requires that the applicable health care licensing boards process special licenses to allow retired health care professionals to volunteer their time in these clinics. House Bill 1328 relates to the State Health Benefit Plan Consumer Choice Option which allows the SHBP to consolidate its network nominating options. Mr. Crutchfield briefly summarized the 2008 Study Committees and Failed Legislation. He also highlighted Passed Legislation, specifically Senate Bill 433 which provides for an extensive review of the Certificate of Need Program, restructures the Health Strategies Council, transfers all licensing authority from DHR to DCH, provides for a CON exemption for Ambulatory Surgery Centers, outlines CON requirements for destination cancer hospitals and other CON process improvements; and HB 1234 , the Medicaid Care Management Organizations Act, that contains provisions related to CMOs that contract with DCH to provide health services for Medicaid and PeachCare members. (A copy of the Summary: 2008 Legislative Session is attached hereto and made an official part of these minutes as Attachment # 3).

Chairman Holmes called on Clyde Reese, General Counsel, to present for final adoption Certificate of Need Rules 111-2-2-.24, 111-2-2-.41, 111-2-2-.42 and 111-2-2-.43. He began with Rule 111-2-2-.41 - Service Specific Review Considerations for Positron Emission Tomography Units. These rules went through the Health Strategies Council (HSC) and Technical Advisory Committee (TAC) process with one point of divergence of what was approved by the HSC and what the Department was proposing. It involved an exception to the need standard for hospitals that would treat as inpatients persons diagnosed with cancer. The Department received 20 written comments opposing this proposed rule change and 0 comments supporting the proposed rules. The basis for the opposition centered on overly broad exception to the need standard within the rule for any hospital that treats as inpatients persons who have been diagnosed with cancer and are undergoing treatment for the disease and who will offer the PET service to its patients through a contract with a mobile PET provider, would result in a proliferation of mobile PET providers. The Department takes the position the proposed exception from the need standard for hospitals which treat inpatients diagnosed with cancer and who will contract with a mobile provider is an access provision that will allow hospitals to potentially offer PET services as a standard of care throughout the state, will not be overly broad, and will encourage the use of mobile providers by small rural facilities who do not have the capital to invest in a PET/CT unit for permanent use at the hospital**.** Mr. Reese asked the board for final adoption of this rule. Mr. Riddle MADE a MOTION to approve CON Rule 111-2-2-.41 for final adoption. Mr. Mason SECONDED the MOTION. Chairman Holmes called for votes; votes were taken. The MOTION was UNANIMOUSLY APPROVED. (A copy of CON Rule 111-2-2-.41 is attached hereto and made an official part of these minutes as Attachment # 4).

Mr. Reese moved on to CON Rules 111-2-2-.42, Specific Review Considerations for MegaVoltage Radiation Therapy Services/Units, and Rule 111-2-2-.43, Specific Review Considerations for Stereotactic Radiosurgical Services. Rule 111-2-2-.42 went through the Health Strategies Council and the Technical Advisory Committee process. One point of divergence between the HSC and the TAC's recommendation and what the Department is recommending is exceptions to the need standard that are contained in the component for non-special MRT services. The Department received three written comments supporting 111-2-2-.42 and twelve comments opposing the proposed rules. One person provided oral comment on the rule change at the March 25, 2008 public hearing. The main item of interest and concern in the proposed new set of service specific considerations for Megavoltage services involves the content of the exception to the need standard for high utilization existing providers who have exceeded 90% utilization of each existing unit over the most recent two-year period. The Department's position is the current exception from the need standard for high utilization providers acts as an unnatural barrier to the entrant of new providers into the state for these services. The revised provision reinserts the exception but would say to those providers that were awarded an additional accelerated unit, by virtue of that exception, the new unit prospectively would not be included in the need calculation or the aggregate utilization calculation going forward for new services in this area. The Department feels that by not including the units awarded pursuant to this exception in the calculation of numeric need and aggregate utilization, the exception will not act as an anti-competitive blocking mechanism for new providers and protect centers of excellence. Some comments were in opposition to proposed changes in the provisions for determining adverse impact and calculating the aggregate utilization in a state service delivery region. This issue was discussed and debated by the HSC and TAC process, and the Department did not make changes to this provision. One comment received objected to a proposed change in the non-special megavoltage radiation therapy rule provisions which would lower the standard for a party to meet a rural access exception to a showing of 150 patients in the first two years of a new service as opposed to the current rule which requires a showing of 200 patients. This issue also was discussed and debated by the HSC and TAC process, and the Department did not make changes to the TAC's provision. The Department received no written or oral comments regarding the proposed repeal of Rule 111-2-2-.43, and since standards and considerations for stereotactic radiosurgery services are included within the proposed rules for megavoltage services, the adoption of Rule 111-2-2-.42 will supersede any need for 111-2-2-.43. Ms. Gay MADE a MOTION to approve CON Rule 111-2-2-.42 for final adoption and repeal Rule 111-2-2-.43. Dr. Parker SECONDED the MOTION. Chairman Holmes called for votes; votes were taken. The MOTION was UNANIMOUSLY APPROVED. (Copies of CON Rules 111-2-2-.42 and 111-2-2-.43 are attached hereto and made official parts of these minutes as Attachments # 5 and 6 respectively).

Mr. Reese discussed CON Rule 111-2-2-.24 – Specific Review Considerations for Perinatal Services. The revised proposed rule provides that an applicant for a Basic Perinatal service in a county with only one hospital or health system offering Level 1 OB services will not be subject to the need standard or the aggregate occupancy standard but would be subject to the adverse impact standard. During the comment period the Department received no comments in support

of and 26 comments in opposition. Four persons provided comments in opposition at the March 25 hearing. In the interim, the 2008 General Assembly passed Senate Bill 433 on April 4, 2008; the Governor signed the bill into law on April 9, 2008; and the CON changes in the bill will be effective on July 1, 2008. The new law would exempt from the general need standard those applicants for Level 1 OB services which would provide services in a county with only one hospital or health system that currently provides that service. However, the statute added another limiting provision; in addition to the requirement there be only one existing provider of Level 1 services in the county where the service would be offered, the bill adds an additional provision that there are not at least three different health care facilities in a contiguous county providing basic perinatal services. Mr. Reese said the Department would like to revise the proposed rule to reflect the additional limiting language of Senate Bill 433. As a result, the Department will have to re-issue the rule for a new public comment period to incorporate this substantive change. He asked the board to table Rule 111-2-2-.24.

Mr. Reese continued with an overview of Senate Bill 433. He said SB 433 started as a bill in the Senate to create a category for designation cancer hospitals. This legislation passed the Senate and moved to the House of Representatives. In the House comprehensive and substantial CON reform was added as an amendment. The bill passed on April 4; the Governor signed into law on April 9, 2008. Mr. Reese said SB 433 is the most comprehensive reform of the CON law in Georgia CON since its inception 1979. The bill incorporated many suggestions of the CON Commission. He provided the board with some highlights of the bill: General Surgery as a single specialty would allow general surgeons to avail themselves of the statutory exemption for single-owned ambulatory surgical centers; abolishes the Health Strategies Council effective July 1, 2008 and reconstitutes a new Health Strategies Council composed of 13 members appointed by the Governor and will serve as an advisory board to the Department; abolishes the Health Planning Review Board and establishes a new CON Appeals Panel composed of five members who are attorneys and will hear administrative appeals of CON applications; revamps and streamlines the appeals process; creates a new category for designation cancer hospitals; streamlines the application review process; provides new enforcement powers; provides additional exemptions for nonclinical services; adds new expenditure thresholds; expands reporting requirements; and transfers some licensing functions from the Department of Human Resources to DCH. The entire Office of Regulatory Services will not be transferred to DCH—only the functions related to hospitals and related institutions including but not limited to surgery centers, nursing homes, traumatic brain injury facilities, home health agencies, personal care homes, background checks on personal care home employees, private duty health care. Mr. Reese said an internal team has been assembled to seamlessly and efficiently integrate ORS into the Department within the next 14 months.

Mr. Reese said staff is working on all administrative rules to reflect the changes brought by the legislation. The intent is to bring the whole body of rules to the board for initial consideration at the July meeting in concurrence with the advent of the law on July 1.

Mr. Reese said the Department has received numerous inquiries about the impact of Senate Bill. The Department has set up, in an attempt to project order and public awareness, a free determination from May 1-May 31, 2008. The Health Planning Division will provide for free requests for determination where they will accept written questions about the bill's impact and applicability to any provider without the required fee and completed form. The questions and answers will be posted on the DCH Web Site as a public service.

Next, Chairman Holmes called on Carie Summers, Chief Financial Officer, to give an overview of the Amended FY 2008 and FY 2009 Budget. Ms. Summers began with the FY 2008 Amended Budget. The Governor signed the Appropriations Act (House Bill 989) on March 21. The impact to DCH is an overall 4.2% increase in total funds but a 3.3% decrease in state funds. In the FY 2009 Budget the impact to DCH is an overall 7.2% increase in total funds and 1.1% increase in state funds. (A copy of the Amended FY 2008 and FY 2009 Budget Summary is attached hereto and made an official part of these minutes as Attachment # 7).

Ms. Summers presented a Resolution for Establishment of Employer Rates for SHBP for FY 2009. This resolution sets the employer contributions rate for the SHBP for FY 2009. The specifics are as follows and are in line with the Appropriations Act: state departments, boards, agencies and authorities' percent of payroll contribution will be reduced to 22.165%; boards of education and RESAs' contributions will remain at 18.534%; non certificated school employees shall continue to be $162.72 per month per participating member; and the amount of dollars that the SHBP can expect from the State Board of Education on behalf of certain retired teachers and non-certificate employees is established at $248,864,058. Mr. Mason MADE a MOTION to approve for adoption the Resolution for Establishment of Employer Rates for SHBP for FY 2009. Ms. Gay SECONDED the MOTION. Chairman Holmes called for votes; votes were taken. The MOTION was UNANIMOUSLY APPROVED. (A copy of the Resolution for

Establishment of Employer Rates for SHBP for FY 2009 is attached hereto and made an official part of these minutes as Attachment # 8).

Ms. Summers gave an overview of eight public notices.

- Dental Services Public Notice – Effective for services provided on or after July 1, 2008, and subject to payment at fee for service rates, the Department proposes to increase dental reimbursement rates by 2.5%. Also, the CMOs are required to increase their current per unit reimbursement rates for their contracted dental providers to effect a rate change comparable to the proposed change in fee-for service rates. The expected cost of this increase is $3.6 million total funds, $1.2 state funds.
- Coverage of Digital Mammography Public Notice – Effective July 1, 2008, the Department proposes to provide coverage of digital mammography services. The services will be reimbursed based on 80% of the 2007 RBRVS as specified by Medicare for the Atlanta area for participating Medicare providers. The expected cost is about $1 million total funds, $358,416 in state funds.
- Home Health Public Notice – Effective for services provided on or after July 1, 2008, and subject to payment at fee for service rates, the Department proposes to increase the cap for home health services to $90 and pay the lesser of the cap or 100% of cost, according to the FY 2006 cost reports. In addition, CMOs are required to increase their current per unit reimbursement rates for their contracted home health providers to effect a rate change comparable to the proposed change in fee-for service rates. The expected cost of this increase is $3.83 million total funds, $1.4 state funds.
- Health Check Services Public Notice – Effective for services provided on or after July 1, 2008, and subject to payment at fee for service rates, the Department proposes to increase Health Check reimbursement rates by 2.5%. The CMOs are required to increase their current per unit reimbursement rates for their contracted providers to effect a rate change comparable to the proposed change in fee for service rates. The expected cost of this increase is $1.6 million total funds, $557,306 state funds.
- Hospital Services – For Inpatient admissions on and after July 1, 2008, the Department proposes to recognize a differential in base rates for hospitals that are Level I-III in the Trauma Network. Those particular hospitals will have their base rates increased by 3.68%. DRG base rates for all other hospitals will be increased by 2.77%. This change does not result in any change in the methodology other than increasing the base rate; this does not mean the Department will do cost settlement. The CMOs are required to increase their current per unit or per admission reimbursement rates for their contracted in patient hospital providers to effect a rate change comparable to the proposed change in fee for service rates. The expected cost of this increase is $43.7 million total funds, $15.6 million state funds. For Outpatient Services, the Department is proposing to modify the payment method for hospital services as follows: payments to hospitals that are designated as a Critical Access Hospital, a historically minority owned hospital or as a state owned hospital are not affected by this public and will continue to be reimbursed in accordance with current policy; for all other hospitals effective for outpatient services provided on and after July 1, 2008 and subject to cost settlement, the percentage of cost coverage will be increased to 90.7% for designated trauma hospitals Levels I through III and 88.3% for all other hospitals; effective for payments made on and after July 1, 2008, the hospital-specific, annual percentage of charges, used to determine interim reimbursement amounts, will be recalculated to consider the increase in cost coverage to 90.7% of cost for designated trauma hospitals Levels I through III and 88.3% for all other hospitals; effective for payments made on and after July 1, 2008, for out of state enrolled hospitals, payments will be made at the statewide average percentage of charges that will be paid to Georgia hospitals being reimbursed at 88.3% of costs; effective for payments made on and after July 1, 2008, the flat rate for non-emergency use of the Emergency Room will be increased from $50 to $60. CMOs are required to increase their current per unit, per admission, or percentage of charges reimbursement rates for their contracted outpatient hospital providers to effect a rate change comparable to the proposed change in fee for service rates effective July 1, 2008.
- Independent Care Waiver Program Public Notice - Effective for services provided on or after July 1, 2008, and subject to payment at fee for service rates, the Department proposes to increase the reimbursement rate for personal support provided through the Independent Care Waiver Program by 3.0%. This scope of service is not covered by the CMOs. The expected cost is about $991, 630 total funds, $355,598 in state funds.
- Physician and Physician- Related Providers (RBRVS) – these are providers who are currently being paid on Medicare's RBRVS reimbursement. Effective for services provided on or after July 1, 2008, and subject to payment at fee for service rates, services will be reimbursed based on 80% of the 2007 RBRVS as specified by Medicare for the Atlanta area for participating Medicare providers. Ms. Summers listed the providers subject to this change and the providers and CPT codes that excluded from

the change. CMOs are required to increase their current per unit reimbursement rates for physician and physician related services as prescribed above for their contracted providers to effect a rate change comparable to the proposed change in fee-for-service rates. The expected cost is $28.9 million in total funds and $10.2 million state funds. An additional change to the Physician and Physican-Related Providers is for providers of global maternity care. Effective July 1, 2008, and subject to payment at fee for service rates, the Department is proposing to increase payment for global maternity delivery physician services as billed under CPT codes 59400, 59510, 59610, and 59618 by 5%. CMOs are required to increase their current per unit reimbursement rates for global maternity delivery payments for CPT codes 59400, 59510, 59610, and 59618 for their contracted providers to effect a rate change comparable to the proposed change in fee-for-service rates. The expected cost is $5.1 million total funds, $1.8 state funds.

- Emergency Ambulance Services - for services provided on and after July 1, 2008, and subject to payment at fee for service rates, the Department is proposing to make the following change to the Medicaid Emergency Ambulance Service (EAS) program as follows: utilize 86% of the CY 2007 Medicare fee schedule for Georgia Locality 01 as the basis for reimbursement for Medicaid covered procedure codes in the EAS program. CMOs are required to increase their current per unit reimbursement rates for their contracted emergency ambulance service providers to effect a rate change comparable to the proposed change in fee-for-service rates. The expected cost is $4.2 million total funds, $1.5 million state funds.

Ms. Gay MADE a MOTION to approve to be published for public comment the Dental Services, Coverage of Digital Mammography, Home Health, Health Check Services, Hospital Services, Independent Care Waiver Program, Physician and Physician-Related Providers, and Emergency Ambulance Services Public Notices. Mr. Mason SECONDED the MOTION. Chairman Holmes called for votes; votes were taken. The MOTION was UNANIMOUSLY APPROVED. (Copies of the Public Notices are attached hereto and made official parts of these minutes as Attachments # 9, 10, 11, 12, 13, 14, 15, and 16).

New Business

Chairman Holmes recognized Representative and Mrs. Gene Maddox for their attendance at the board meeting.

Adjournment

There being no further business to be brought before the Board, Chairman Holmes adjourned the meeting at 12:24 p.m.

THESE MINUTES ARE HEREBY APPROVED AND ADOPTED THIS THE _____ DAY OF

_____, 2008.

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RICHARD L. HOLMES
Chairman

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Secretary

Official Attachments:

#1	List of Attendees	#10	Coverage of Digital Mammography Public Notice
#2	Agenda	#11	Home Health Public Notice
#3	Summary: 2008 Legislative Session	#12	Health Check Services Public Notice
#4	Rule 111-2-2-.41	#13	Hospital Services Public Notice
#5	Rule 111-2-2-.42	#14	ICWP Public Notice
# 6	Rule 111-2-2-.43	#15	Physician and Physician-Related Providers Public Notice
# 7	Amended FY 2008 and FY 2009 Budget Summary	#16	Emergency Ambulance Service Public Notice
# 8	Resolution for Establishment of Employer Rates for SHBP for FY 2009		
# 9	Dental Services Public Notice		